Medicaid Select

Medicaid Select Reassignment Request Form

P.O. Box 1484, Indianapolis, IN 46209-9200 Fax: (317) 488-2446

***Medicaid Select* Provider** _____ **Provider ID** _____

Provider Address _____**City**_____**Zip Code**_____

We are requesting that the member(s) below be removed from our panel. *(Please list different families on separate request forms.)*

Name _____ ID# _____

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The reason for this request is circled below.

1. **Missed Appointments** - Please provide appointment dates. If less than three appointments have been missed, also include a copy of your office policy regarding missed appointments for all patients.

2. **Member Fraud** - Please state the circumstances leading to this suspicion or conclusion. Drug seeking behavior is considered member fraud.

3. **Threatening, Abusive or Hostile** – The member or a family member has displayed this type of behavior towards the provider or staff members. Please include the date(s) of and brief description of the incident.

4. **Medical Needs Better Met by Another Provider** - Please provide documentation of member's condition and explanation of the reason for the decision.

5. **Breakdown of the Physician /Patient Relationship** - Please provide explanation and documentation that the breakdown is mutual.

6. **Member Accessing Care from Another Provider** - Please provide documentation to support this conclusion. Note: Abuse of the Emergency Room is ***not*** a reason for reassignment!

7. **Previously Approved Reassignment** – Appropriate reason when member was previously reassigned but placed back on panel through error or auto-assignment. May also be used when previous request was denied due to ending eligibility or when the member is reassigned to another PMP in the same practice. Please provide a copy of your original reassignment request for the member.

8. **Member Previously Terminated from Practice** – Appropriate reason when member was terminated from practice prior to becoming eligible through *Medicaid Select*. Please provide documentation such as a copy of the previous letter that advised the member of termination.

9. **OB Reassignments** - Physician is contracted to serve pregnant members only and member is no longer pregnant. Please provide delivery date.

Please be sure to send the appropriate documentation with your request. You ***must*** send a copy of the letter you sent to the member advising them of the reassignment request. This information will assist us in providing member education to minimize future problems. It will also allow us to process your request more quickly.

Person completing this form _____ Phone Number _____

Date _____

Revised 11/02